

# AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please Answer All Questions Completely

Date \_\_\_\_\_ No. \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Sex:  Male  Female Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Company Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

Name of driver of vehicle in which you were injured (self/other) \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
Phone No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_  
Name of agent who has made contact with you \_\_\_\_\_  
Have you retained an attorney? If so, his/her name, address, and phone number:  
\_\_\_\_\_

Driver of OTHER vehicle (if any) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Address \_\_\_\_\_  
Phone No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_  
Name of agent who has made contact with you \_\_\_\_\_

Please explain in detail how your accident happened? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Time and date present injury occurred \_\_\_\_\_  
You were driving north/south/east/west on \_\_\_\_\_ (street/highway).  
You were struck from:  Behind  Front  Left Side  Right Side  
You were:  Driver  Passenger  Front Seat  Back Seat  Using Seat Belts  
Number of people in your vehicle \_\_\_\_\_  
Were police notified?  Yes  No Did head strike windshield or object?  Yes  No  
Were you knocked unconscious?  Yes  No If so, for how long? \_\_\_\_\_  
Did you feel pain immediately after the accident?  Yes  No  
If not, when did pain begin? \_\_\_\_\_  
Where did you feel pain immediately after the accident? \_\_\_\_\_  
Where were you taken after the accident? \_\_\_\_\_  
Was any doctor consulted after the accident?  Yes  No  
If so, doctor's name \_\_\_\_\_  
Doctor's diagnosis \_\_\_\_\_ Was treatment given?  Yes  No  
How often/long did you see the doctor? \_\_\_\_\_  
Have you ever had any complaints in the involved area before? If so, please describe:  
\_\_\_\_\_

Before injury, were you capable of working on an equal basis with others your age?  Yes  No  
Are your work activities restricted as a result of this accident?  Yes  No  
Since the injury, your symptoms have:  improved  worsened  stayed the same

# HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ No.: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES  NO

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

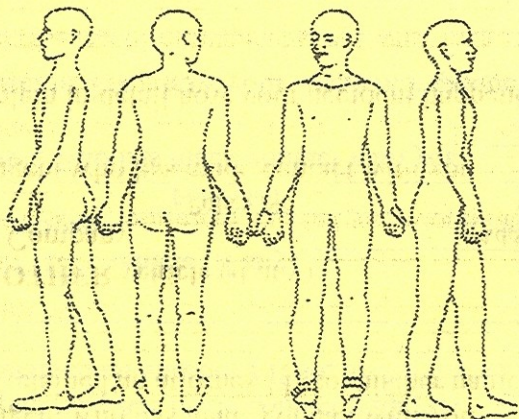
## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- \_\_\_\_\_

### SYMPTOM LOCALIZATION



- P \_\_\_ Pain                      T \_\_\_ Tender  
 N \_\_\_ Numb                     H \_\_\_ Hypoesthesia  
 S \_\_\_ Spasm

### Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature \_\_\_\_\_

..... DO NOT WRITE BELOW THIS LINE .....

Patient Accepted?  Yes  No      Doctor's Signature \_\_\_\_\_